



**TAXICAB VEHICLE  
LICENSE APPLICATION**  
**THIS APPLICATION IS SUBJECT TO REVIEW BY THE PUBLIC**  
**PLEASE TYPE OR PRINT IN INK**

**CITY OF SAINT PAUL**  
Department of Safety  
and Inspections  
375 Jackson Street, Suite 220  
Saint Paul, Minnesota 55101-1806  
(651) 266-9090 Fax (651) 266-9124  
**Web:** [www.stpaul.gov/dsi](http://www.stpaul.gov/dsi)

**LICENSES ARE NOT TRANSFERABLE  
PAYMENT MUST BE RECEIVED WITH EACH APPLICATION**

Name license will be held under: \_\_\_\_\_

Applicant's name (if different): \_\_\_\_\_

Applicant's home address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Name of Taxicab Company: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mail to Address: \_\_\_\_\_

Previous experience in taxicab business: \_\_\_\_\_

Detailed description of the color scheme, including inscriptions and monograms, of taxicabs to be licensed (must be distinctly different from that of other licensed taxicabs in Saint Paul): \_\_\_\_\_

Vehicles to be licensed (proof of title must be furnished):

**Note:** A taxicab vehicle licensee must be affiliated with a taxicab company which has a minimum of five vehicles.

<u>Vehicle Owner</u>	<u>MN License Plate #</u>	<u>Year/Make/Model</u>	<u>Vehicle Identification #</u>

If applying for additional licenses, please put additional vehicle information on an attached sheet.

A certificate of liability insurance must be furnished (showing the required coverage) for the above vehicles, and must include a clause requiring a 30-day written notice to the City of Saint Paul of cancellation before its expiration date.

**CERTIFICATION OF WORKERS' COMPENSATION COVERAGE PURSUANT TO MINNESOTA STATUTE 176.182**

I hereby certify that I, or my company, am in compliance with the workers' compensation insurance coverage requirements Minnesota Statute 176.182, subdivision 2. I also understand that provision of false information in this certification constitutes sufficient grounds for adverse action against all licenses held, including revocation and suspension of said licenses.

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Coverage from \_\_\_\_\_ to \_\_\_\_\_

I have no employees covered under workers' compensation insurance \_\_\_\_\_ (INITIALS)

**MINNESOTA TAX IDENTIFICATION NUMBER** - Pursuant to the Laws of Minnesota, 1984, Chapter 502, Article 8, Section 2 (270.72) (Tax Clearance; Issuance of Licenses), licensing authorities are required to provide to the State of Minnesota Commissioner of Revenue, the Minnesota business tax identification number and the social security number of each license applicant.

Under the Minnesota Government Data Practices Act and the federal Privacy Act of 1974, we are required to advise you of the following regarding the use of the Minnesota Tax Identification Number:

- This information may be used to deny the issuance or renewal of your license in the event you owe Minnesota sales, Employer's withholding or motor vehicle excise taxes;
- Upon receiving this information, the licensing authority will supply it only to the Minnesota Department of Revenue. However, under the federal Exchange Information Agreement, the Department of Revenue may supply this information to the Internal Revenue Service.

Minnesota Tax Identification Numbers (Sales & Use Tax Number) may be obtained from the State of Minnesota, Business Records Department, 600 Robert Street North, Saint Paul, MN (651-296-6181).

Minnesota Tax Identification Number: \_\_\_\_\_

☐ If a Minnesota Tax Identification Number is not required for the business being operated, indicate so by placing an "X" in the box.

**ANY FALSIFICATION OF ANSWERS GIVEN OR MATERIAL SUBMITTED  
WILL RESULT IN DENIAL OF THIS APPLICATION**

I hereby state that I have answered all of the preceding questions and that the information contained herein is true and correct to the best of my knowledge and belief. I hereby state further that I have received no money or other consideration, by way of loan, gift, contribution, or otherwise, other than already disclosed in the application which I herewith submit.

\_\_\_\_\_  
Signature (REQUIRED for all applications) Date

Preferred methods of communication from this office (please rank in order of preference - A1" is most preferred):

\_\_\_\_ Phone Number with area code: (\_\_\_\_) \_\_\_\_\_ Extension \_\_\_\_\_

(Circle the type of phone number you have listed above): Business Home Cell Fax Pager

\_\_\_\_ Phone Number with area code: (\_\_\_\_) \_\_\_\_\_ Extension \_\_\_\_\_

(Circle the type of phone number you have listed above): Business Home Cell Fax Pager

\_\_\_\_ Mail \_\_\_\_\_

Street (#, Name, Type, Direction) City State Zip+4

\_\_\_\_ Internet: \_\_\_\_\_

E-Mail Address

**We will accept payment by cash, check (made payable to City of Saint Paul) or credit card (MasterCard or Visa).**

**IF PAYING BY CREDIT CARD PLEASE COMPLETE THE FOLLOWING INFORMATION:** Card Type: \_\_\_\_\_

EXPIRATION DATE:

ACCOUNT NUMBER:

\_\_\_\_\_  
Name of

Cardholder (please print) Signature of Card Holder (required for all charges)

Date